



DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service



TB Notes
No. 3, 2001

Dear Colleague:

On October 4 in Seattle, I participated in a review of the TB projects funded by the Bill & Melinda Gates Foundation. It was most gratifying to see the progress to date in the development and implementation of these projects. While there, I had the opportunity to visit with Dr. Helene Gayle, the recently-departed Director of the National Center for HIV, STD, and TB Prevention (NCHSTP), who moved to Seattle at the end of August to become the Senior Medical Advisor on HIV, STD, and TB for the Gates Foundation. On August 27 Dr. Gayle was replaced at CDC by Dr. Harold Jaffe, Director, Division of AIDS, STD, and TB Research Laboratory, (DASTLR), National Center for Infectious Diseases (NCID), who was designated Acting Director, NCHSTP. CDC will conduct a national search for a permanent Director of NCHSTP. This process will likely take several months.

The Advisory Council for the Elimination of Tuberculosis (ACET) met on October 10 and 11 in Atlanta, Georgia. After the welcome and introductions, Dr. Harold Jaffe and I gave the NCHSTP and DTBE Directors' Reports. Staff of the Office of the Inspector General of the General Accounting Office will visit CDC in spring 2002 as part of their review of the process and systems involved in TB control among INS detainees. This visit had originally been scheduled for September 18 and 19 but was postponed after the events of September 11. We heard a report on CDC's role in response to those events from Kathy Cahill, CDC's Associate Director for Policy, Planning, and Evaluation. CDC and the New York City (NYC) health department were quick to respond; 7 hours after the attacks, the first CDC team was en route. Over the next few days, more CDC epidemiologists were sent to conduct surveillance in hospitals. Four of DTBE's Epidemic Intelligence Service (EIS) officers were among 71 CDC staff who assisted in NYC in response to the terrorist attacks. They were assigned to NYC hospitals, where they worked long, hard hours. We are glad to have them safely back in Atlanta. Several DTBE staff attended the US/Mexico binational health meeting that was held October 14-16 in El Paso, Texas. One goal of the meeting was to develop a binational health card, to help improve TB treatment in persons who frequently cross the US/Mexico border. On October 22 and 23, Dr. David Fleming, CDC's Deputy Director for Public Health and Science, represented CDC at a meeting of the "Stop TB" initiative in Washington, DC. This meeting was in follow-up to the meeting that was held in March 2000 in Amsterdam and attended by officials from the 22 countries with the world's highest TB incidence. After the Directors' Reports, Dr. Jack Crawford of DASTLR, NCID, gave an explanation of a new technology for TB subtyping called mycobacterial interspersed repeated unit, or MIRU. This technology is based on detecting a series of repeated elements that exist throughout the TB genome; it has an intermediate specificity between IS6110 fingerprinting and spoligotyping. Dr. Tom Shinnick, also of DASTLR, suggested improving TB laboratory services by enhancing national and regional laboratory systems. Dr. Elsa Villarino of our Research and Evaluation Branch gave an update on tuberculin skin testing, and led a discussion on the relative merits of the two commercially available reagents. Mr. John Seggerson, DTBE's Associate Director for External Relations, reviewed the history of the Strategic Plan for TB Training and Education. This initiative is at an important juncture in that it needs funding in order to continue its activities. He announced that the committee will not disband; it will continue its important work

while looking for additional sources of funding. Members of ACET expressed their support for the Strategic Plan and its continuation. Next we heard a report on the epidemiology of TB in the Southeast United States from Lilia Manangan of the Surveillance and Epidemiology Branch (SEB), which was followed by a discussion of health disparities among different US population groups. Michael Iademarco, DTBE Associate Director for Science, reported on the continuing investigation into adverse events associated with taking 2 months of rifampin and pyrazinamide (2RZ) for latent TB infection (LTBI). As of October 10, CDC had received 83 reports of adverse events associated with treatment for LTBI. Of these, 27 met the case definition for this investigation (hospitalization or death associated with 2RZ for LTBI); six of these case-patients died. The investigations will continue; most likely a retrospective analysis will be conducted in order to capture more information about this public health challenge. Dr. Masae Kawamura, San Francisco TB controller, presented a draft *MMWR* on treating TB in persons detained by the Immigration and Naturalization Service (INS) and requested comments from ACET members on the document. Dr. Renee Ridzon of SEB gave an update on the draft revised infection control guidelines for health care workers; the group hopes to have a final draft at least by January 2002. Dr. Scott McNabb, also of SEB, discussed the status of the new TB Epidemiology Studies Consortium (TBES); 22 applicants were approved and 14 of these received funding. We heard expressions of disappointment from applicants who were approved but not funded; I requested that they submit their comments formally, in writing, to CDC's Procurement and Grants Office to preclude future misunderstandings.

The 4th World Congress on Tuberculosis will be held in Washington, DC, on June 3-5, 2002. Details will be published shortly. This meeting will evaluate the state of the global TB epidemic since the last Tuberculosis World Congress in 1992, review the status of TB research, and identify research gaps. Topics covered will include fundamental, translational, and operational research. Attendance should be of interest to global TB control officials, TB researchers, health systems services researchers, policymakers, and funders, as well as infectious disease and pulmonary physicians. Meeting organizers include the National Institute of Allergy and Infectious Diseases and the Fogarty International Center of the US National Institutes of Health, the World Health Organization's Special Programme for Research and Training in Tropical Diseases (TDR) and "Stop TB" initiative, the CDC, the US Agency for International Development, and the KNCV (the Royal Netherlands Tuberculosis Association). In addition, please note that the 2002 TB Controllers Workshop is tentatively scheduled for the week of June 17, 2002. Walt Page, president of the National TB Controllers Association (NTCA), is arranging meeting space in the Washington, DC, area.

DTBE and its partners have a number of documents in varying stages of preparation and completion. CDC's plan in response to the Institute of Medicine (IOM) report, *Ending Neglect: The Elimination of Tuberculosis in the United States*, has been finalized and will go through clearance after editing. The Federal TB Task Force response to the IOM report has been finalized and is being formatted and edited; after clearance, it will be submitted for publication in CDC's *Morbidity and Mortality Weekly Report (MMWR)* Recommendations and Reports series. The final draft of the CDC/ American Thoracic Society (ATS)/Infectious Disease Society of America (IDSA) statement on the treatment of TB is undergoing final review and will receive formative evaluation prior to publication. The document will be published in the *American Journal of Respiratory and Critical Care Medicine*, and will be reprinted as an *MMWR* with no changes. The ACET document on TB in low-incidence areas is moving through clearance. DTBE's Dr. Jerry Mazurek had an article published in the October 10 issue of the *Journal of the American*

Medical Association, titled "Comparison of a whole blood interferon-gamma assay with tuberculin skin testing for detecting latent *Mycobacterium tuberculosis* infection" (*JAMA* 2001;286:1740-1747). The US TB surveillance and morbidity report for the year 2000 has been sent to the *MMWR* office for publication. And the DTBE publication *Core Curriculum: What the Clinician Should Know* has been translated into Spanish. This document, which has been revised and updated several times since its initial publication, presents basic information about TB to health care professionals. Following my final review of the translated document, it will be printed and available for ordering.

Thank you for your continued hard work and dedication to the challenges of TB control. Please know that whatever your specific duties entail and wherever you do them, your contributions matter. Together, we are making a difference.

Kenneth G. Castro, MD

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TB Notes

Centers for Disease Control and Prevention
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Division of TB Elimination ♦ National Center for HIV, STD, and TB Prevention

Number 3, 2001

HIGHLIGHTS FROM STATE AND LOCAL PROGRAMS

Farewell Note from Dr. Davidson of Los Angeles County

Dr. Davidson presented the following information and comments at a meeting of the California Public Health Commission prior to his retirement. He gave permission for his remarks to be reprinted in TB Notes.

I will be retiring from County service October 1, 2001, after completing 18 years as Director of Tuberculosis Control for Los Angeles County, California. These have been eventful years, full of twists and turns in the circumstances related to the control of TB as well as in the many changes in the California Department of Health Services and Public Health. I believe I can honestly say that I will leave the control of TB in a more favorable condition for the County than when I arrived. I regret to say that there is still a long way to go before this disease can be eliminated in Los Angeles. However, at the current level of disease, the possibility of elimination is at least in sight.

I would like to summarize some of the important trends in the incidence of tuberculosis in Los Angeles County and some of the outcome accomplishments related to program objectives. I will conclude by making a few general reflections as I begin to fade out of the picture.

During the year 2000 the number of cases of reported TB declined for the eighth year in a row at 1065. This is a 9% decline from the number in 1999 and outpaced both the State of California and the United States, which have also had 8 years of declining incidence. The incidence of TB is at a historical low for all these jurisdictions.

There has also been a decline in the number of cases in all races and ethnic groups during the past 8 years. Persons of Asian and of black race continue to be overrepresented and white persons underrepresented as compared to the overall population. Hispanics are equally represented.

The number of cases by age group has declined most dramatically in the 15 to 34 age group during the past 8 years. However, there has been a leveling in the number of cases in this age group during the past 4 years. The 65-and-older age group has remained level for many years and contributes the second largest number of cases. As tuberculosis is controlled and gradually eliminated, the 65-and-older age group will become the predominant group in terms of cases and incidence. The corollary to this is that the number of cases in the 0 to 14 age group should be the first age group to approach 0 if TB is fully under control and moving toward elimination.

The number of cases of TB in both the foreign-born and the U.S.-born has declined

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during the past 8 years. However, the percentage of cases in foreign-born persons has been steadily increasing from 62.6% in 1990 to 72.7% in 2000. Since TB continues to be out of control in many parts of the world, the foreign-born population may be the Achilles heel that will make the elimination of tuberculosis in Los Angeles County very difficult.

The cases in persons infected with HIV and in the homeless have reached an all-time low in 2000 with 77 and 76 cases, respectively. A decline in the control of the spread of HIV or a serious downturn in the economy could adversely affect TB in these populations. The same would hold true with persons who have multiple risk factors such

as being foreign-born, homeless, and HIV infected.

Considerable effort is being placed on setting objectives and measuring outcomes for all public health programs. Los Angeles Tuberculosis Control, in collaboration with the State of California and CDC, has been evaluating program effectiveness and documenting outcomes related to TB for many years. Our ability to participate in this process has been dramatically increasing with the availability of computerized data systems and the strengthening of the data management and epidemiology staff at Tuberculosis Control and in the Health Centers. Directly observed therapy (DOT) is a highly effective program activity that ensures that patients receive their medications. The number of TB patients receiving DOT has steadily increased since 1995. Our objective is to reach 100% of all cases being managed with DOT.

The CDC national objective regarding the percentage of TB patients who should complete a prescribed course of therapy within 12 months is 85%. In 2000, Los Angeles County performed at the 65% level. There are a number of factors that inhibit our reaching this objective such as patients dying, moving, or taking longer to complete therapy. We have very little ability to control some of these factors. Overall a very high percentage of patients who are started on treatment in Los Angeles County eventually complete treatment if they do not die within the first 12 months. A very small percentage of patients (1.9%) are lost to follow-up.

Los Angeles County has exceeded the national objective of 92% in drug susceptibility testing for a number of years with 98.5% in 2000. This is a reflection on the excellent Public Health Laboratory support we have in Los Angeles County.

New guidelines concerning preventive therapy were published by CDC/ATS this past year. The Tuberculosis Control Program for Los Angeles County recently approved and circulated the standards expected for Los Angeles County. These standards are based on the CDC/ATS and the State of California guidelines. Among the changes has been the terminology. "Treatment of latent tuberculosis infection" (LTBI) is now preferred to that of "preventive therapy." One of the highest priorities for treatment of LTBI is for contacts of contagious cases of TB. The national objective for treating contacts is that 85% should complete treatment of LTBI. The 1999 cohort of contacts in Los Angeles County only completed therapy in 47.3%. The national objective for completing treatment of LTBI in other groups that are targeted because of increased risk is 75%. The results of completing treatment by the community-based organizations that had contracts with the County were 52.8%, significantly below the set objective. Testing those at high risk for tuberculosis infection and successfully treating those with LTBI will need to be a higher priority for the Tuberculosis Control Program in coming years as we move toward elimination of this disease.

In conclusion, a great deal of work must be done before we can declare victory over TB. I believe the following are some of the more important aspects for Los Angeles Public Health to address in coming years to ensure the decline and eventual elimination of this disease:

- Every effort must be made to maintain the necessary infrastructure to get the job of eliminating TB done. This includes maintaining level and in some cases increased funding despite decreasing numbers of cases.

- The treatment of TB is a specialty. It will be necessary to maintain specialty clinics staffed by experienced, appropriately trained physicians, nurses, and support personnel.
- The availability of DOT is essential to the eventual elimination of TB. This includes availability to patients cared for by both the private and public sectors.
- There should be continued efforts to establish TB specialty clinics in strategically located full-service outpatient facilities.
- As TB declines it will be increasingly found in members of limited subsegments of the population, many of whom will be difficult to reach and serve. New programs will be necessary to successfully eliminate TB in these populations. Examples of such populations include the elderly, the homeless and the poor, the undocumented foreign-born, and the mentally ill.
- Maintenance of incentives and enablers will remain an essential part of eliminating TB. New and innovative approaches will be necessary. Flexibility will be essential.
- A highly skilled field services staff will be necessary to find cases as early as possible and test and find those at risk for developing disease. Supervision of treatment with DOT and other enablers is critical. Innovation is also necessary here. The roll of community workers and other nonlicensed persons should be expanded into testing, case finding, and providing treatment services for

cases and those on treatment of LTBI.

- Above all, the first priority is to prevent the transmission of TB. Only then will there be an emerging succession of generations free of infection, without risk of developing disease, vigorously marching toward the elimination of this amazingly persistent disease.

—Paul T. Davidson, M.D.
Director, Los Angeles TB Control

Childhood Screening for TB in Texas

As TB continues to decrease in Texas, the strategies to control and prevent its spread must change to target those populations most at risk. On January 18, 2001, the Texas Department of Health (TDH) convened a group of pediatric TB experts, which was designated the Blue Ribbon Committee on Childhood TB, to consider the best strategies for controlling TB disease and infection in children. In May and June, the Committee's recommendations and a questionnaire developed by the committee to help in screening for risk of TB exposure were presented for review and comment to groups with an interest in child health. These included representatives from TDH programs that provide services to children and representatives from school districts and other state agencies.

In July TDH sent a copy of the recommendations and the questionnaire to local and regional health departments and asked them to work with school districts to use the risk assessment questionnaire in place of universal TB skin testing, which some school districts were continuing to require for all children entering their schools. The questionnaire asks about exposure of children to adults with symptoms or risk factors for TB. Children for whom positive

responses are given to the questions about risk factors should be evaluated for TB infection with a tuberculin skin test and followed appropriately.

Use of the questionnaire is recommended for school entry in seven counties in Texas where the 3-year average rate of TB is double the state rate. In six counties that have a 3-year average rate of TB that is 50% to 99% higher than the average rate for Texas, the decision to require TB screening with the questionnaire for school entry should be a joint decision of the local health department and the school district, as resources allow.

The "Health Steps" program in Texas, which provides screening and health services for Medicaid-eligible children, plans to adopt the questionnaire for TB screening as the program revises its service delivery guide manual in 2002.

—Submitted by Phyllis Cruise
CDC Senior Public Health Advisor
and Ann Tyree
Communications Specialist
TB Elimination Division, Texas Dept of Health

Meeting of New TB Controllers Association

The Northern Rocky Mountain TB Controllers Association held its inaugural meeting on July 27, 2001. Mr. Alex Bowler, TB Control Officer for the State of Wyoming, invited participants to Jackson Hole, Wyoming, for the first annual meeting of this new regional conference.

Those accepting Alex's invitation were Drs. Christine Hahn (Idaho) and Randall Reves (Denver), Ms. Denise Ingman (Montana), Ms. Kristin Rounds (South Dakota), Ms. Pat Infield (Nebraska), and Mr. Walt Page, Executive Director of the National TB Controllers Association (NTCA).

Two DTBE Program Consultants, Andy Heetderks and Scott Jones, were in attendance as well; they presented a brief update on CDC activities and discussed the FY 2002 Cooperative Agreement. The TB Control Officers from Utah and North Dakota had been invited, but were unable to attend.

The agenda for this meeting was similar in format to the Midwestern and Southeastern TB Controller Conferences. Each TB Controller presented a program overview with emphasis on a particular aspect. For example, the Nebraska and South Dakota TB controllers emphasized the impact of refugee resettlement on programs with limited resources, which prompted a helpful discussion of approaches and strategies from the other participants.

All attendees voiced their appreciation for the opportunity to meet as a region. Some stated that a regional focus was very helpful, in that suggestions and solutions were immediately transferable between states with similar challenges. A tentative agreement was reached to meet again next year; Ms. Ingman of Montana volunteered to act as host for the second annual Northern Rocky Mountain TB Controllers Association.

—Reported by Scott Jones
Division of TB Elimination

Update on CDC's Response to *Ending Neglect: the Elimination of Tuberculosis in the United States*

As you know, the Institute of Medicine (IOM) released a report entitled *Ending Neglect: the Elimination of Tuberculosis in the United States* in May of 2000. CDC had commissioned the report, asking the IOM to determine the feasibility of TB elimination as

a national goal. If feasible, then the IOM had been further asked to provide specific recommendations as to how to make elimination a reality.

The IOM determined that TB elimination in the United States was feasible, but stated that "to meet this goal aggressive and decisive actions beyond what is now in effect will be required." Furthermore, "elimination of TB is not possible with the tools we currently have available. An effective elimination campaign will require additional financial resources and a strong, durable commitment by policy makers." CDC agrees with these conclusions.

The Division of TB Elimination (DTBE) is leading CDC's effort to develop a plan of action in response to the IOM report. This document, *CDC's Plan to Eliminate Tuberculosis from the United States*, reflects the scientific, programmatic, and health-sector developments of the last decade and supercedes the 1989 *Strategic Plan for the Elimination of Tuberculosis in the United States*. The goals, objectives, and action steps that comprise CDC's new strategy for TB elimination will serve as a guide for CDC's work, in collaboration with its partners, to finally rid the nation of the human suffering and societal harm caused by TB infection and disease.

The plan is organized around six goals that frame TB elimination efforts in the context of the IOM's recommendations. The goals and corresponding objectives are as follows:

Goal I: Maintain control of TB incidence
Maintain the decline in TB incidence through timely diagnosis of active TB disease, appropriate treatment and management of persons with active disease, investigation and appropriate evaluation and treatment of contacts of infectious cases, and prevention of transmission through infection control.

Objectives:

- Maintain and enhance local, state, and national public health surveillance for TB.
- Support the infrastructure needed for laboratory-based identification and treatment of TB
- Ensure that patient-centered case management and monitoring of treatment outcomes are the standard of care for all TB patients.
- Develop community partnerships, and strengthen community involvement in TB control.
- Improve the timely investigation and appropriate evaluation and treatment of contacts with active TB disease and latent TB infection.
- Ensure appropriate care for patients with multidrug-resistant (MDR) TB, and monitor their response to treatment and their treatment outcomes.
- Ensure that health care facilities maintain infection-control precautions.

Goal II: Accelerate the decline

Advance toward TB elimination through targeted testing and treatment of persons with latent TB infection, appropriate regionalization of TB control activities, rapid recognition of TB transmission using DNA fingerprinting methods, and rapid outbreak response.

Objectives:

- Increase the capacity of TB control programs to implement targeted testing and treatment programs for high-risk persons.
- Promote the appropriate regionalization of TB control activities in high, intermediate, and low TB-incidence areas of the United States.
- Characterize circulating *M. tuberculosis* strains using DNA

fingerprinting methods.

- Develop national, state, and local capacity to respond to outbreaks of TB.

Goal III: Create new tools

Develop and assess new tools for the diagnosis, treatment, and prevention of TB.

Objectives:

- Develop a coordinated plan for TB research.
- Develop new methods to diagnose persons with latent TB infection and to identify infected persons who are at high risk of developing active TB.
- Develop and assess new drugs to improve TB treatment and prevention.
- Develop a new and effective TB vaccine.
- Develop and implement a program of research on behavioral factors related to TB treatment and prevention.
- Rapidly transfer findings from research studies into practice.

Goal IV: Reduce the global reservoir of TB

Increase involvement in international TB control activities.

Objectives:

- Provide leadership in public health advocacy for TB prevention and control.
- Provide technical support and build capacity for implementation of DOTS.
- Develop models for the diagnosis and treatment of patients with MDRTB.
- Provide technical, programmatic, and research support to reduce the incidence of TB as an opportunistic disease in high HIV-burden countries.

Goal V: Summon and sustain support

Mobilize and sustain support for TB elimination by engaging political leaders, opinion leaders, organizational partners, policy makers, health care providers, affected communities, and the public. Implement a comprehensive health communication campaign that supports elimination strategies and ensures the development and delivery of effective TB control messages.

Objectives:

- Develop and implement a media communications campaign focusing on the resources and support needed for TB elimination.
- Help communities foster nontraditional, multisectoral, public-private partnerships to improve the effectiveness of their communications activities, with particular attention to culturally appropriate materials.
- Support the development of state- or area-specific TB elimination plans that contain communications activities to build support for TB elimination.

Goal VI: Track progress

Monitor progress toward the goal of TB elimination, and make regular reports on progress to all target audiences.

Objectives:

- Develop innovative analyses for examining surveillance data to help focus elimination efforts.
- Develop novel indicators of progress toward elimination.
- Conduct periodic evaluations of TB program performance at federal, state, and local levels.
- Conduct an annual progress review.

CDC's Plan to Eliminate Tuberculosis in the United States complements a more

comprehensive federal plan, under development by the multiagency TB Task Force, to respond to the IOM's recommendations. Implementation of these plans will set in motion the activities needed to arrest TB in the United States.

The CDC plan has been presented to the Advisory Council for the Elimination of TB (ACET) for review and comment. State and local TB controllers have also provided comments through the National TB Controllers Association (NTCA). We will keep you informed as work progresses on the plan and make copies of the plan available to you when it is finalized.

—Reported by Paul Poppe
Deputy Director
Division of TB Elimination

UPDATES FROM THE COMMUNICATIONS AND EDUCATION BRANCH

TB ETN First Annual Meeting and Workshop

On August 1-3, 2001, TB trainers and educators gathered in Atlanta, Georgia, for the first annual TB Education and Training Network (TB ETN) Meeting and Workshop. The theme of this groundbreaking workshop was "Culture, Language, and Literacy in TB Education and Training." TB ETN members from across the country and U.S. territories traveled to attend this workshop that was dedicated solely to health education, training, and communication issues.

Participants praised the quantity of information they received and the number of skills they learned during the workshop from dynamic speakers such as Patricia Wren from the University of Michigan School of Public Health and Tawara Goode from the National Center for Cultural Competence.

Speakers not only shared valuable insights into culture and literacy, but also provided participants with many cultural competency resources to take home for future reference. A social that was hosted by the National TB Model Centers gave participants the opportunity to network with colleagues and to share and discuss educational materials developed in various states.

During the meeting, participants had the opportunity to discuss and make decisions about the future of the TB Education and Training Network. Participants were enthusiastic about the benefits of being a part of the Network and indicated that this year's workshop was a great beginning for collaboration and meetings in the future.

For more information about the TB Education and Training Network, please contact Maria Fraire at (404) 639-5317 or mff8@cdc.gov.

*—Submitted by Betsy Carter, MPH, CHES
Division of TB Elimination*

DTBE's Web Site and Section 508

On June 21, 2001, a law went into effect that gives disabled individuals increased access to electronic and information technology provided by the federal government. Section 508 of the Rehabilitation Act of 1973, as amended, requires that federal agencies develop, procure, maintain, or use electronic and information technology that is accessible to individuals with disabilities, unless an undue burden would be imposed on the agency. Section 508 applies to all federal government information technology systems including PCs, software, and office equipment such as copiers and fax machines. However, much of the focus of the new regulations surrounds the requirement to make federal Web sites accessible to people with disabilities.

We have been working diligently to make the DTBE Internet site compliant with Section 508. For instance, we have been testing our HTML pages to ensure that a "screen reader" — a technology that reads aloud, in an artificial voice, the words and punctuation marks that appear on a computer monitor — can function on the site. Screen readers cannot read images (icons, buttons, or graphics), so we have created alternative text that will appear when you roll over an image with a mouse. This text will provide a meaningful description of each graphic, allowing screen readers to convey the purpose of the image. In addition to adhering to a list of other technical specifications, we have provided an accessibility link at the bottom of our Web site for anyone who has difficulties accessing information on the site.

You may have noticed some changes on the DTBE Internet site while we have been converting information to meet the new accessibility standards. Because of the time and effort it takes to convert some of our large documents into an accessible format, some pages have been temporarily removed from the site. For example, selected Surveillance Reports from 1999 and 2000 are not available, and reports prior to 1999 have been removed. These reports will be available in upcoming months.

In the future, we plan to provide a text-only version of the DTBE Internet site so that the site will not only be Section 508 compliant, but will also be available for use on wireless devices. For more information on DTBE's related activities, contact Maria Fraire at mmf8@cdc.gov; for more information on Section 508, visit www.section508.gov.

*—Reported by Betsy Carter, MPH, CHES
Division of TB Elimination*

INTERNATIONAL ACTIVITIES UPDATE

International Activities in Peru

In August 2000, the Bill and Melinda Gates Foundation awarded a 5-year grant of \$44.7 million to the collaborating group PARTNERS (Partnership Against Resistant Tuberculosis: A Network for Equity and Resource Strengthening). This collaboration is made up of the National Tuberculosis Program of Peru, the Program in Infectious Disease and Social Change and Partners in Health at Harvard Medical School, the World Health Organization, the Task Force for Child Survival and Development, and CDC. The goals of this group are to 1) demonstrate in one country (Peru) the success of an integrated TB control program that can contain drug-resistant TB; 2) develop the infrastructure necessary to support this program model and make it exportable to other settings where drug-resistant TB is a problem; 3) export this program model and evaluate its effectiveness in at least one other hot spot of drug-resistant TB; and 4) help develop an integrated TB control model that can support a WHO/CDC-led strategy for global TB elimination.

CDC representatives in this partnership to date have included members of International Activities (IA), the Research and Evaluation Branch (REB), and the Communications and Education Branch (CEB). Together, we have contributed to the development of studies to examine and compare individualized and standardized regimens; examine contacts of MDRTB cases; evaluate prognostic factors for death of MDRTB patients, including the role of HIV infection; and evaluate the cost-effectiveness of different MDRTB regimens and treatment strategies. Through this partnership, CDC is also participating in the development of a core data set with consistent definitions for the collection of MDRTB data globally. We are also planning to participate in the organization of a

workshop or meeting to discuss operational research needs for this project and for MDRTB control and management in general. Finally, CDC has participated in the assessment of infection control needs in hospitals in Lima, Peru.

—*Reported by Kayla Laserson, ScD*
Division of TB Elimination

CDC Technical Assistance in Three Russian Oblasts**1. Ivanovo Oblast**

CDC, the World Health Organization (WHO), and the U.S. Agency for International Development (USAID) officially assumed responsibility for support of the basic directly observed therapy, short-course (DOTS) program in Ivanovo Oblast as of January 1, 2000. (An oblast is comparable to a state.) CDC staff provided training during the first two quarters, and also developed and implemented an incentive program for patients and employees. As a result of implementation of the incentive program, significant improvements are being seen in patient outcomes (increased cure and completion rates) and decreased default rates.

One of the most significant forms of technical assistance provided by CDC staff is training. In February 2001, a CDC laboratory consultant taught a course in basic mycobacteriology, assembled and demonstrated the use of new equipment delivered by WHO, trained staff, and provided laboratory evaluations at the oblast dispensary. The topics covered in the course were specimen collection, acid-fast microscopy, isolation by culture, drug-susceptibility testing, laboratory safety, and quality assurance. CDC staff also made arrangements for a laboratory consultant from the State of Florida to stay in Ivanovo during the months of February and March

and work onsite with Ivanovo staff to improve their skills and assist with laboratory methods. The outcome has been excellent in terms of improved validity of drug susceptibility testing results. CDC coordinated the work of the consultant there with ongoing project activities, and is working to implement the consultant's recommendations. CDC has also been actively planning an infection control course. Masks were procured and will be provided to the oblast lab and medical staff in preparation for the course.

CDC, WHO, and USAID began evaluating cohort performance as of July 1, 2000. New patients are now enrolled in the DOTS program under the new CDC/WHO/USAID DOTS protocol. DOTS performance outcomes have begun to improve in the Ivanovo Oblast due to intensive supervision.

Summary data for patients enrolled in the second quarter of 2000 are as follows: out of 170 patients, 125 completed and were cured (73.5%), 15 died (8.9%), 15 failed treatment (8.8%), 10 defaulted (5.9%), and 5 transferred out (2.9%). The newly implemented incentive program has significantly increased the percentage of patients completing treatment. Preliminary data indicate an 81.3% success rate for patients registered in the third quarter of 2000 in Ivanovo city. The region began working with the prison sector during the second quarter of 2001.

2. Orel Oblast

The project was initiated on October 1, 1999, with plans to gradually phase in all patients over the course of a year. New and retreatment patients from both the civilian and the prison sector are being registered and managed in accordance with the DOTS program. Also, a DOTS-Plus project is to be launched in Orel in January 2002.

CDC again provided the basic course in mycobacteriology that was taught in Ivanovo, assembled and demonstrated new equipment delivered by WHO, trained staff, and provided laboratory evaluations at the oblast dispensary from February 24 to March 9, 2001. Data continue to indicate that the Orel site is implementing the WHO TB control strategy very well. CDC, WHO, and USAID are giving strong consideration to establishing the Orel site as a training center for other regions in Russia that are or will be implementing the WHO TB control strategy.

Summary data from the Orel Oblast provide the following for the first and second quarter of 2000 for all smear-positive patients, including Category II patients in the civilian and prison sectors: out of 172 patients, 121 completed and were cured (70%), 10 died (5.8%), 16 failed treatment (9.3%), 8 defaulted (5.6%), 4 transferred out (2.3%), and 13 are continuing treatment with the outcome pending at this time (7.5%). It is expected that the patients with a pending outcome will have a successful one, which will increase the total success rate to 78% (134 patients). These outcome results are exceeding expectations, considering that new treatment regimens for Category II patients have not been implemented during this cohort period. Orel Oblast continues to document the viability of a successful DOTS project in Russia with few additional resources. Success rates among new pulmonary cases range between 75% to 78% for smear-positive patients and 85% to 86% for all patients. A drug-resistance survey was initiated in August and is now completed. The results have been shared with WHO and the region. The combined level of MDRTB among civilian and prison TB cases without prior history of treatment is 3.7%; however, among retreatment cases the combined MDRTB level is 30%.

3. Vladimir Oblast

The DOTS project was initiated on October 2, 2000, with plans to gradually phase in patients over the course of a year, including new and retreatment patients. Over 300 patients were registered into the program in the civilian sector during the first two cohorts and 114 patients were registered in the prison sector in the first cohort. Overall, physicians in the civilian sector are following the treatment protocol correctly; however, in the prison sector there were some systematic deviations. After the last monitoring mission there were still many unresolved issues that had been raised previously in this oblast. CDC recommended making concrete short-term and long-term plans for addressing the most pressing issues (connecting laboratory equipment, improving drug management practices, identifying a mechanism by which to implement patient incentives and enablers) by the end of June 2000. Other issues that need special attention and improvement in this oblast include smear microscopy performance; timeliness in reporting from the raion to the oblast level (a raion is a district or municipality, comparable to a county); case management; and training of prison physicians.

A patient incentive plan was drafted and is currently being evaluated by the oblast administration. In February 2001, laboratory technicians from the Vladimir Oblast attended the 5-day training course in basic mycobacteriology that was taught in Ivanovo. The CDC laboratory consultant also supervised the presentation of a 3-day course on acid-fast microscopy held by the Vladimir Oblast Dispensary Laboratory staff for raion laboratory staff.

—Reported by Gustavo Aquino, MPH
Division of TB Elimination

The New LIFE Act and Impact on U.S. Health Departments

Background

The Legal Immigration Family Equity (LIFE) Act was introduced by Hal Rogers (R-KY), Chair, House Appropriations Subcommittee on Commerce, Justice, State, and the Judiciary in 2000. It passed as H.R. 5548 on December 21, 2000. The purpose of the LIFE Act is to encourage immigrant family reunification. There are several elements of this new law, but the facet of the LIFE Act that relates to public health is the addition of a new nonimmigrant visa (NIV) or temporary status category (V visa) for spouses and dependent children of permanent residents (green card holders) who have been waiting 3 years or longer for their permanent residence. A number of other NIV applicant categories already exist, including visitors (B visa), students (F visa), temporary workers (H, J, and L visas), and fiancées (K visa).

The underlying intent of the LIFE Act is to reunite families that have been or could be subject to long periods of separation during the process of immigration to the United States. It also addresses the current Immigration and Naturalization Service (INS) backlog for approving family-based petitions. For any family member to be eligible for the new V status, he or she must satisfy the following three criteria:

- Be the spouse or unmarried child (younger than 21 years of age) of a permanent resident
- Have the family-based petition filed with INS on or before December 21, 2000
- Have the family-based petition awaiting INS approval for at least 3 years, or have the petition approved by INS but 3 years have passed since the filing date of the petition and no green card has been issued.

Therefore, the total number of people eligible for V status will not be determined until December 21, 2003.

Impact on U.S. Health Departments

Most NIV applicants, such as visitors (B visa), students (F visa), and temporary workers (H, J, and L visas), are not required to have a medical examination before coming to the United States. However, the fiancée (K visa) applicant, whose visa implies that the applicant is coming to the United States to live permanently, is required to have an overseas medical examination. Using this precedent, the law requires that those people outside of the United States and eligible for the new V status have an overseas medical examination by a panel physician. Panel physicians are those local physicians who have been designated by a U.S. embassy or consulate to perform the medical examination for immigration purposes. The examination will include all elements of the medical examination required for immigrants (for example, screening for TB, human immunodeficiency virus, syphilis, and certain mental disorders). However, because these people are applying for V status, immunizations will not be required until they apply for adjustment of status within the United States. The INS has also indicated that regulations for those already in the United States and eligible to change to V status will require that a medical examination be performed by an INS-designated physician (civil surgeon). However, the INS is still in the process of developing the regulatory guidance addressing this issue.

Many of the V visa applicants will be coming from countries with TB incidences that are higher than the United States incidence (see table). As it does with other foreign-born people receiving an overseas TB classification (Class A: acid fast bacilli smear-positive, suggestive of active; Class

B1: acid fast bacilli smear-negative, suggestive of active; or Class B2: suggestive of inactive), the Division of Global Migration and Quarantine (DQ) will notify receiving health departments of the TB classifications of these people as they arrive.

DQ is currently in communication with U.S. consulates and embassies and with the INS to find the best method of identifying V visa applicants with Class A and Class B TB conditions when they enter the United States. Furthermore, DQ is communicating with the Department of State and INS about the lack of an alien number for these V visa applicants and what can be used as a replacement.

These new V visa applicants will need to have immunizations at the time they adjust their statuses to permanent residency. Because more than a year will probably pass from the time the V visa is issued and permanent residence is applied for, these V visa holders will be required to undergo another medical examination by an INS-designated civil surgeon in the United States.

To date, almost 7,000 V visas have been issued in Ciudad Juarez, Mexico, 2,000 in Santo Domingo, Dominican Republic, and almost 700 in Manila, Philippines.

*—Submitted by Mary Naughton, MD, MPH,
Pam Copelan, and Susan Cookson, MD
Division of Global Migration and Quarantine*

Table. Posts Expecting to Process >1,000 V Visas:

| Region | | |
|---------------------------------------|------------------------------|--|
| Post | Min. Expected Numbers | 1999 WHO TB Rate* for All Types |
| <u>Africa</u> | | |
| Accra, Ghana | 1873 | 281 |
| Addis Ababa, Ethiopia | 1305 | 373 |
| Lagos, Nigeria | 1753 | 301 |
| <u>Asia</u> | | |
| Guangzhou, China | 3933 | 103 |
| Ho Chi Minh City, Vietnam | 2264 | 189 |
| Manila, Philippines | 6958 | 314 |
| <u>Latin America/Caribbean</u> | | |
| Bogota, Colombia | 1954 | 51 |
| Ciudad Juarez, Mexico | 206,667 | 39 |
| Georgetown, Guyana | 1722 | 101 |
| Guatemala City, Guatemala | 2391 | 85 |
| Guayaquil, Ecuador | 2231 | 172 |
| Havana, Cuba | 1967 | 15 |
| Kingston, Jamaica | 3664 | 8 |
| Lima, Peru | 1367 | 228 |
| Port au Prince, Haiti | 6267 | 361 |
| San Salvador, El Salvador | 4758 | 67 |
| Santo Domingo, Dominican Republic | 14,596 | 135 |
| Tegucigalpa, Honduras | 2415 | 92 |
| <u>Indian Sub-continent</u> | | |
| Dhaka, Bangladesh | 3435 | 241 |
| Islamabad, Pakistan | 2162 | 177 |
| Mumbai, India | 1387 | 185 |
| New Delhi, India | 1375 | 185 |
| <u>Eastern Europe</u> | | |
| Warsaw, Poland | 3791 | 39 |
| <u>Other Posts</u> | 16,622 | |
| Total | 296,857 | |

*Rate: Reported incidence of all types of TB per 100,000 population. Source: World Health Organization. Global Tuberculosis Control. WHO Report 2001. WHO, Geneva, Switzerland.

NEWS BRIEFS

Surveillance data for the year 2000 were posted on October 2, 2001, to the DTBE Web site: www.cdc.gov/nchstp/tb. You will find it on the DTBE Home page under "What's New."

Several NTCA workgroup meetings were held this fall. On Oct. 18 and 19 the NTCA met with CDC staff to discuss the development of a "hands-on" genotyping manual for TB controllers. The NTCA Information Technology Workgroup met with CDC staff on Nov. 6 for what is being called a TIMS summit. Also, the NTCA Contact Investigation Workgroup met Nov. 15 and 16.

Please note that a new drug called Remicade, which is labeled and approved for use in patients with rheumatoid arthritis, is associated with reactivation of latent TB infection. Because of this reaction, persons receiving Remicade should first receive a tuberculin skin test, and should not take the drug if found to have latent TB infection.

NEW CDC PUBLICATIONS

Alonso-Echanove J, Granich RM, Laszlo A, Chu G, Borja N, Blas R, Olortegui A, Binkin NJ, and Jarvis WR. Occupational transmission of *Mycobacterium tuberculosis* to health care workers in a university hospital in Lima, Peru. *Clin Infect Dis* 2001; 33: 589-596.

Besser R, Pazik B, Schulte JM, Alvarado S, Zell E, Kenyon TA, Onorato IM. Risk factors for positive Mantoux tuberculin skin tests in children in San Diego, California: evidence for boosting and possible foodborne transmission. *Pediatrics* 2001;108(2):305-310.

Bock N, Rogers T, Tapia JR, Herron GD, DeVoe B, Geiter LJ. Acceptability of short-

course rifampin and pyrazinamide treatment of latent tuberculosis infection among jail inmates. *Chest* 2001; 119(3): 833-37.

Braden CR, Morlock GP, Woodley CL, Johnson KR, Colombel AC, Cave MD, Yang Z, Valway SE, Onorato IM, and Crawford JT. Simultaneous infection with multiple strains of *Mycobacterium tuberculosis*. *Clin Infect Dis* 2001; 33: e42-e47.

CDC. Update: Fatal and severe liver injuries associated with rifampin and pyrazinamide for latent tuberculosis infection, and revisions in American Thoracic Society/ CDC recommendations — United States, 2001. *MMWR* 2001; 50(34): 733-752.

Espinal MA, Laserson K, Camacho M, et al. Determinants of drug-resistant tuberculosis: analysis of 11 countries. *Int J Tuberc Lung Dis* 2001; 5(10): 887-893.

LoBue PA, Moser K, Catanzaro A. Management of tuberculosis in San Diego County: a survey of physicians' knowledge, attitudes, and practices. *Int J Tuberc Lung Dis* 2001; 5 (10): 933-938.

Mazurek GH, LoBue PA, Daley CL, Bernardo J, Lardizabal AA, Bishai WR, Iademarco MF, Rothel JS. Comparison of a whole-blood interferon γ assay with tuberculin skin testing for detecting latent *Mycobacterium tuberculosis* infection. *JAMA* 2001; 286(14): 1740-1747.

Saiman L, Aronson J, Zhou J, Gomez-Duarte C, San Gabriel P, Alonso M, Maloney S, Schulte J. Prevalence of infectious diseases among internationally adopted children. *Pediatrics* 2001; 108(3): 608-612.

The Tuberculosis Trials Consortium: A model for clinical trials collaborations. *Public Health Reports* 2001(Supplement 1); 116: 41-49.

PERSONNEL NOTES

Tracy Agerton, RN, MPH, has returned to DTBE in Atlanta after 2 years in Berkeley, California. She was there participating in long-term training, pursuing and completing most of the requirements for a PhD in epidemiology. Tracy has been part of DTBE since 1996, when she came to the Surveillance and Epidemiology Branch (SEB) as an Epidemic Intelligence Service (EIS) Officer. She has now returned to DTBE, where she is a member of the International Activities staff and completing her postdoctoral work. One of her first projects will be focused on conducting an annual risk of infection survey in Botswana. She will also be collaborating on projects in Vietnam and serving as the DTBE liaison to CDC's Global AIDS Program (GAP).

McKenzie Andre, MD, is the Surveillance and Epidemiology Branch's new first-year Epidemic Intelligence Service (EIS) Officer. McKenzie received his BA from Yale, where he studied ethics, politics, and economics, and his MD from Howard University College of Medicine in 1998. He completed his internal medicine residency at St. Luke's - Roosevelt Hospital in New York City. McKenzie joins the Outbreak Investigations Section. McKenzie and the Division's other EIS Officers (Puneet Dewan, Lisa Nelson, and Lorna Thorpe) were among the first group of EIS Officers sent to New York City after the terrorist attacks on September 11, 2001.

Carol Berglund has joined DTBE as a new member of the Tuberculosis Information Management System (TIMS) team in the Computer and Statistics Branch. She had previously worked in the National Immunization Program (NIP) in the Data Management Division (DMD) starting in May 1996, working with the Vaccines for Children (VFC) program and the Vaccine

Management System (VACMAN). The VFC program helps children receive free immunizations within their state; the VACMAN system is implemented nationally and used by the states to order vaccines through CDC and track related data. Carol's responsibilities included providing recommendations for system design and computer programming based on VFC policy and feedback from the Immunization Public Health Managers and VACMAN customers, and also provided user training for the VACMAN system. From 1991 to 1996 Carol worked in the Public Health Practice Program Office (PHPPPO) in the Information Resource Management (IRM) Activity; prior to that she was with the Department of Defense (DOD).

Viva Combs, MPH, CHES (Certified Health Education Specialist), started September 24, 2001 as program manager/health scientist in the Epidemiologic Studies Section, Surveillance and Epidemiology Branch, DTBE. She will be working to help establish and support the Tuberculosis Epidemiologic Studies (TBES) Consortium. Viva recently graduated from the Public Health Prevention Specialist (PHPS) Service and Training Program. This is a 3-year, on-the-job national training program for masters-level public health workers, sponsored by EPO. Viva performed her CDC-based service with one year in Atlanta and her state-based practical duty in years 2 and 3 in Columbia, South Carolina. She has a BS in Biology and a BA in Spanish, and spent her last semester studying in Spain. She received her masters degree in public health from Indiana University in Health Education and Promotion. She not only has an interest in the impact of HIV -TB coinfection among African American communities, but also in other special populations (e.g., prison inmates and immigrants). She is interested in developing epidemiologic profiles for the United States and assessing certain sociodemographic,

sociocultural, and socioeconomic factors: the contextual factors that may affect an HIV-positive person's susceptibility to TB. Finally, like all of us, she is interested in the global TB epidemic.

Melanie N. Davis, MS, has begun a 6-month appointment in the Epidemiologic Studies Section of the Surveillance and Epidemiology Branch as a Public Health Prevention Specialist Fellow. Melanie received her bachelors degree in psychology and her masters degree in science in community health from the University of Arkansas. Melanie will be working on a number of activities related to the Branch's TB genotyping work, including conducting a needs assessment of TB control officials to determine the specific needs of programs in integrating genotyping information into TB control and elimination activities, and coordinating a national meeting of the TB Genotyping Working Group to develop a hands-on manual describing the practical applications of genotyping to TB control. Melanie's duties related to the manual will also include developing its outline, coordinating tasks assigned to Working Group members, and developing a time line for its completion. Prior to coming to CDC, Melanie worked in the University of Arkansas Health Promotions Office as a graduate assistant, where she facilitated a substance abuse class, planned on-campus health events (e.g., health fairs, alcohol awareness week activities, etc.), and conducted peer education.

Dave Elmore reported to the Computer and Statistics Branch on September 10. Dave previously worked as a Senior Systems Analyst in CDC's Information Resources Management Office (IRMO), Management Information Systems Branch, for over 10 years. During his tenure in IRMO, Dave was Project Manager, Technical Lead, and Systems Analyst on numerous projects,

including the Executive Controlled Correspondence (ECC) system, Enterprise Human Resource & Payroll (EHRP) initiative, and numerous CDC/Information Systems Applications. Before coming to CDC, he was a contractor for a consulting firm and also served in the United States Air Force for over 22 years. Dave assumed the duties of the TIMS technical lead, the position formerly held by Ken Long, when he arrived in DTBE.

Odile Ferroussier, MPH, joined DTBE's International Activities in September as an ASPH Fellow to conduct cost-effectiveness studies of various programs and interventions. Originally from France, Odile received a BA in public administration from the Institut d'Etudes Politiques in Grenoble, France, before moving to the United States to study international relations at the University of Colorado in Boulder. She has worked as a translation coordinator in the private sector as well as for the Atlanta Committee for the Olympic Games. She has also worked as a Research Associate conducting program evaluations for The Atlanta Project of the Carter Center in Atlanta, and for the Chapin Hall Center for Children in New York. More recently, after completing a masters degree in public health at Emory University, Odile worked in DTBE's Research and Evaluation Branch in the Prevention Effectiveness Section, conducting a cost-effectiveness study of contact investigations, and in the Epidemiology Program Office's Division of Prevention Research and Analytic Methods, developing economic evaluation teaching materials. She is currently enrolled in a PhD program in public policy and program evaluation at Georgia State University.

Larry Johnson, a first-year Public Health Advisor assigned to the Orange County TB Control Program in Orlando, Florida, has left DTBE and accepted a position in Jacksonville with the U.S. Department of

Labor. Larry started with DTBE in January 2001 as a member of the new PHA cohort. In a farewell note to his coworkers, Larry stated that this had not been an easy decision for him, but he felt it was best for his family in Jacksonville. During his short tenure with CDC, Larry established himself as a "can-do" PHA, and we wish him well in his new position.

Olga Joglar, MHSA, has been selected for the Chief, Field Operations Section 1. Olga joined DTBE in 1989 when she was selected as the Senior Public Health Advisor for Puerto Rico's TB Program. From 1992 to 1995, Olga was assigned to the New York City Bureau of TB where she was responsible for spearheading the multiple drug-resistance team, providing leadership to the outreach unit, and directing outreach activities in Brooklyn, the borough with the highest incidence of TB. Olga transferred to Atlanta in 1995 to work as a program consultant for several mid-West states and big cities, Puerto Rico, and the Virgin Islands.

Heather Joseph, MPH, has joined the Research and Evaluation Branch as an ASPH Fellow. She came to us from New Orleans, Louisiana, where she completed her masters degree in public health with a concentration in epidemiology. Between obtaining her undergraduate degree in anthropology and completing her graduate work, she was a Rotary Fellow in New Delhi, India, where she studied at the Center for Social Medicine and Community Health at Jawaharlal Nehru University. Her course work there included social sciences, the political economy of health, and the structure of the public health system within India. During her MPH work at Tulane, she participated in a project evaluation of a community-based access-to-care initiative of a local nonprofit organization and also worked with the Louisiana Turning Point Program. The Turning Point Program, which

is sponsored by the Robert Wood Johnson Foundation, is a state-based public health planning initiative that emphasizes collaboration, community development, and capacity building. During Heather's fellowship, she will be working primarily on two qualitative research projects: an ethnographic survey of foreign persons to ascertain beliefs, practices, and attitudes from several distinct ethnic groups, and an assessment of the reasons behind health care workers' adherence or nonadherence to testing guidelines and treatment for LTBI.

Steve Kammerer has joined the Division and is working in the Surveillance and Epidemiology Branch as a contract database manager. In this role, Steve will receive, review and validate incoming data for the National Tuberculosis Genotyping and Surveillance Network (NTGSN) project. He will also provide technical assistance to NTGSN site participants and provide support to senior scientists in the analysis and summary of project data. Steve received his BS in mathematics from the College of William and Mary and his MBA from Virginia Polytechnic Institute. He brings 15 years of experience in corporate data processing, marketing experience in customer data analysis in SAS, and forecast model development. In addition, Steve has 6 years' experience running a small business including consulting and training, proposal writing, project management, and software design and development.

Bernadette Ford Lattimore, MPH, completed her Public Health Prevention Specialist assignment with the Research and Evaluation Branch (REB), Prevention Effectiveness Section (PES), on August 16. During her 6-month assignment, she completed a literature review focusing on cultural competence issues relevant to TB control and prevention. Using this information, she designed a research

protocol and developed data collection instruments for an upcoming ethnographic study of TB knowledge and attitudes of foreign-born persons. Bernadette successfully presented her design to the Division on August 9. She began her next CDC assignment in Chicago in September, where she will be working to bring community groups and local health care providers together to help prevent STDs and HIV.

Tze-San Lee, PhD, joined the Computer and Statistics Branch September 4 as a biostatistician. Dr. Lee received his PhD in Applied Mathematics and Statistics from State University of New York at Stony Brook in 1976. After that he taught at National Chung-Hsing University in Taiwan for a year, and for 2 years at Michigan State University. Since 1980 he has been teaching and being promoted to the rank of a tenured full professor at Western Illinois University until coming to work at CDC. Besides teaching courses in statistics, Tze-San also conducts research through a collaboration with scientists at various government laboratories including Argonne National Laboratory, the U.S. Air Force's Armstrong Laboratory, the FDA's National Center for Toxicological Research, and NASA. He has published articles on the mortality of the thorium-processing plant workers who were exposed to radon, the prevalence of lead poisoning in young children of the families who were living in the U.S. Air Force on-base and off-base housing, and the compliance of workers who were exposed to asbestos dust to the OSHA's standard based on the unequally spaced time series data.

Ken Long has left DTBE to accept a job offer with CDC's National Center for Environmental Health. Ken came to DTBE in 1997 from CDC's Information Resources Management Office (IRMO) to serve as the technical lead for the TB Information

Management System (TIMS). Throughout his career he has had extensive experience with client-server computer systems such as TIMS and was instrumental in launching CDC-WONDER. Ken's last day with DTBE was August 24.

Susan Maloney, MD, MHS, has accepted the position of Acting Associate Director for Science of the Division of Global Migration and Quarantine (DQ) in the National Center for Infectious Diseases. Susan has been with DQ since 1997 and previously served as DQ's Acting Chief, Surveillance and Epidemiology Branch.

Stuart McMullen has left the Field Services Branch of DTBE and has joined the CDC Global AIDS Program (GAP). On August 12, 2001, Stuart accepted a 2-year assignment with GAP, and will be detailed to Malai, Africa. Stuart started his career with CDC in 1989 in the Ft. Lauderdale, Florida, STD training program. He had subsequent assignments with the STD program to Philadelphia in 1990, and to the County of Los Angeles STD program in 1992. He transferred to DTBE in June 1993, with his assignment to the County of Los Angeles TB Control program and was last assigned by the DTBE in March 1996 to the TB Control Branch, California Department of Health Services in Berkeley, California.

Mary Naughton, MD, MPH, has joined DQ, National Center for Infectious Diseases, as the new TB medical officer for the Migration Health Assessment Section in the Field Operations Branch. Mary received her training in radiology from Duke University and Beth Israel Hospital in Boston and her MPH from Harvard University. Prior to receiving her MPH, Mary practiced radiology in Massachusetts for 8 years. She will be dealing with the day-to-day operational issues regarding TB among immigrants, refugees, and U.S. adjustment-of-status applicants.

Gabe Palumbo has been selected for the vacant senior public health advisor position in the Michigan TB Control Program. Gabe joined the DTBE field staff in February 1993 with an assignment to the New York City (NYC) TB Program. His assignment to NYC provided him with a broad understanding of public health and knowledge about programmatic issues and clinical services. In January 1996, he was reassigned to the New York State TB Control Program with responsibilities for both Nassau and Suffolk counties. In October 1997 Gabe was assigned to the Wisconsin TB Program where he provided consultation and technical advice on state-wide TB program development and assistance to local jurisdictions. In January 1999 he was selected for the senior PHA position in Hawaii where he was responsible for TB program management activities. Gabe reported to Lansing, Michigan, on August 14. He will be responsible for providing technical advice and assistance to the Michigan TB Program as well as working with local health departments in TB prevention and control efforts.

Kathleen Perez-Hureaux has resigned from DTBE, Field Services Branch (FSB), effective September 6, 2001, to pursue other interests in Seattle, Washington. In 1997 Kathleen joined the New York City TB Control Program as a Senior Public Health Educator. In January 1999 she was promoted to Director, Education and Training Unit. Kathleen was then selected for a public health advisor position in the New York City TB Control Program in February 2000. During the past year and a half she has been responsible for the overall direction and development of the education and training unit for the city's TB control program, managing and supervising all staff assigned to the unit.

Joe Posid, MPH, joined DTBE in July to coordinate activities related to TB among

special populations, including correctional facilities. Joe has had over 25 years with CDC, both in the field and at headquarters in Atlanta. He has had field assignments with the former National Center for Prevention Services (the forerunner of the National Center for HIV, STD, and TB Prevention) in New York City, Chicago, and Puerto Rico, then with the National Center for Infectious Diseases (NCID) in Alaska. His headquarters assignments have included serving as the Emergency Response Coordinator with the National Center for Environmental Health (NCEH) and as a staff epidemiologist with the Agency for Toxic Substances and Diseases Registry (ATSDR) before working for the past 9 years in various assignments in HIV/AIDS. He received his BA from City University of NY and his masters degree in public health in epidemiology from Emory University in Atlanta.

Noreen Qualls, PhD, MPH, has been selected to head up the DTBE Research and Evaluation Branch's Prevention Effectiveness Section (PES). Noreen joined PES in July 1997 as a Health Policy Analyst after completing a 2-year postdoctoral prevention effectiveness fellowship in environmental health at CDC. Her work in the section has focused on conducting decision and economic analyses related to contacts, foreign-born persons, and TB suspects and on providing prevention effectiveness training courses for state and local disease control staff members. She has served as the Acting Section Chief since September 1, 2000. Noreen received her masters and doctoral degrees in public health from the Department of Health Policy and Administration, School of Public Health, University of North Carolina at Chapel Hill.

Audrey Reichard, MPH, joined the division as an ASPH fellow in the Field Services Branch in September 2001. She received her undergraduate degree in occupational

therapy from Ohio State University and completed her masters degree in public health at Emory University. She recently completed a 2-year fellowship with the National Center for Injury Prevention and Control where she worked on projects related to traumatic brain injury and spinal cord injury, including central nervous system injury surveillance and a pressure sore prevention program evaluation. Audrey will be working on a project focusing on missed opportunities for preventing cases of pediatric TB and latent TB infection.

Mary Reichler, MD, is transferring from the Surveillance and Epidemiology Branch (SEB) to the Research and Evaluation Branch (REB) to help the division address unmet needs in new TB diagnostics research and development. Mary will continue to oversee contact investigation studies focusing on the identification of surrogate markers of TB infection and disease.

Eric Williamson was selected for a public health advisor (PHA) position in Los Angeles, California, and has transferred there from Missouri. In his most recent assignment, he served as a PHA in Jefferson City, Missouri, where he functioned as an assistant to the senior PHA, Vic Tomlinson, and state public health officials. Among other assignments and projects, Eric assisted with the investigation of the MDRTB outbreak in St. Louis, Missouri. Eric began working at CDC in 1991 in the STD program as an assignee to the Chicago Training Center. In December 1992, he transferred to Memphis, Tennessee. In June 1997, he accepted reassignment to the state of Wisconsin, and in August 1999 he was selected for the PHA position in Jefferson City, Missouri. Eric started his assignment with Los Angeles on June 17.

Misty D. Worley, MPH, CHES, began a 2-

year fellowship sponsored by the Association of Schools of Public Health (ASPH) with the Communications and Education Branch (CEB). Misty received her masters degree in public health in health education from the University of Oklahoma in July 2001. During the pursuit of her master's degree, Misty was actively involved in a variety of settings, such as her work as a graduate research assistant for the "Oklahoma Teen Pregnancy Prevention Evaluation Project" in the College of Public Health. While working, she had the opportunity to serve on the executive board of the Teen Pregnancy Coalition of Oklahoma County, Inc., the Oklahoma Public Health Association, the College of Public Health Student Association, and a variety of other steering committees. Misty also completed a 192-hour internship with the Oklahoma City County Health Department's TB Control Center prior to graduating. While enrolled as a student at the University of Oklahoma, she was nominated for the Outstanding College of Public Health Student Award and was the recipient of the annual Joan K. Leavitt Award. She started in CEB in September 2001.

CALENDAR OF EVENTS

December 13-16, 2001

2001 ICAAC Conference

41st Interscience Conference on Antimicrobial Agents and Chemotherapy Chicago, Illinois

www.asmta.org/mtgsrc/41ICAAC.htm

January 14-17, 2002

International Symposium on Current Developments in Drug Discovery for TB National Science Seminal Complex Indian Institute of Science Campus Bangalore, INDIA

Registration deadline: December 15, 2001
For more information, contact:

AstraZeneca Foundation India
(Attn: Symposium Secretariate)
277 Sri T Chowdaiah Road Malleswaram
Bangalore - 560 003 INDIA
Tel: 91-80-3340-372; fax: 91-80-3340-449
E-mail: cdtb@astrazeneca.com
Web site: www.cdtb.astrazenecaindia.com

February 6-7, 2002

**Meeting of the Advisory Council for the
Elimination of TB
Atlanta, Georgia**

CDC

Contact John Seggerson at (404) 639-8120

February 28-March 2, 2002

**7th Conference of the IUATLD North
American Region
Vancouver, Canada**

For more information, please contact:
Conference Secretariat of the IUATLD N.
American Region

Menn Biagton

British Columbia Lung Association

2675 Oak Street

Vancouver, BC, CANADA V6H 2K2

Tel: (+1 604) 731 5864

Fax: (+1 604) 731 5810

E-mail: info@bc.lung.ca

March 24-27, 2002

**International Conference on Emerging
Infectious Diseases
Atlanta, Georgia**

Abstracts invited beginning Aug 1, 2001.

Tel: (202) 942-9248

E-mail: meetinginfo@asmusa.org

Web site: www.cdc.gov/iceid

June 3-5, 2002

**The 4th World Congress on
Tuberculosis
Washington, DC**

Details to follow
